Perspectives

IDEAS AND OPINIONS

Forced Labor

GIVING BIRTH HAS BECOME A MEDICAL EMERGENCY IN THE UNITED STATES. HOW DID IT HAPPEN? BY CYNTHIA K. BUCCINI

WHEN A WOMAN about to give birth enters a U.S. hospital — and 99 percent of them do these days — she probably will be strapped to an electronic fetal heart rate monitor and may also be tethered to an IV. She might be given drugs to induce or speed up labor, and she may undergo an unexpected cesarean section.

Despite these and a host of other medical procedures, the United States has one of the worst records in maternal and infant mortality among industrialized countries, writes Jennifer Block (CAS'98, SED'98) in her new book, *Pushed: The Painful Truth About Childbirth and Modern Maternity Care* (Da Capo Press).

"When women go into the hospital, they're going to experience interventions that don't necessarily have to do with their health and well-being and their baby's health and well-being, but that have become routine because of liability concerns and malpractice insurers' requirements and all of these things that have nothing to do with the medical evidence," says Block, a Brooklyn-based freelance writer and a former associate editor at *Ms.* magazine.

She points to the electronic fetal monitor. "In the hospital, 95 percent of women, according to surveys, have to wear an electronic fetal monitor," she says, "which is no better than a nurse coming in and listening periodically with a stethoscope or with an electronic Doppler monitor. The fetal monitor, when it's on continuously, as it often is, really limits mobility. So women are now in bed."

When did childbirth become a medical emergency? Block set out to write a magazine article about that and similar questions, but the subject proved too big and complex to wrestle down to a few pages. In *Pushed*, she explores the "intense medical management" of childbirth, the rising cesarean rate, and the difficulties some women face in finding alternatives to a hospital birth.

YOU SAY THAT IN THE UNITED STATES TODAY, WE DON'T SUPPORT THE PHYSIOLOGICAL BIRTH PROCESS. WHAT DO YOU MEAN BY THAT?

The physiological birth process is the automatic sequence of events that happens to a woman's body during labor: the contractions start, many hormones start pumping, the cervix starts opening, and the baby starts moving down.

We know that the healthiest thing for both the mother and the baby is to support this process and to have a minimally invasive vaginal birth. That's the optimal experience, one in which the mother goes into labor naturally, moves around throughout labor, pushes in an upright position — standing, squatting, sitting — or on hands and knees. Most women, if they give birth vaginally, are pushing in very counterproductive positions, either on their backs or lying back. They're being told when to push and how long to push.

> "It's not that women want a natural childbirth. They just want a normal birth."
> —Jennifer Block

More than half of women are receiving synthetic oxytocin, the drug Pitocin, to either induce or speed up labor. According to surveys, about four out of ten women are being induced into labor. Nearly a third of women are going through major abdominal surgery to give birth. For the women who give birth vaginally, a third of them are getting episiotomies. These practices, we know from research, contribute to all sorts of problems: incontinence, sexual pain, recovery pain. Cesareans can lead to major complications. We know that these practices don't make for an optimal birth expe-

ILLUSTRATION BY PEP MONTSERRAT; INSET PHOTO BY ADAM BLOCK

rience, yet most women are still experiencing them.

YOU WRITE THAT WE CONSIDER CHILDBIRTH A MEDICAL CONDITION THAT NEEDS TO BE CONTROLLED. WHAT'S CONTRIBUTING TO THIS TREND?

There is a lot going on, but I think the overarching problem is we're not valuing physiological birth. We have this idea that a cesarean is just as good, that mimicking labor—inducing labor with drugs and instruments—is the same, and the research shows that it's really not.

The process works much more efficiently when it's allowed to take its own course. Babies benefit greatly from labor, and breast-feeding is much easier. I think there is a collective distrust of the female body and a lack of trust that it can do this work of labor.

We want the support and the medical technology if we need it, and that's really important. Women and babies die when there's a lack of emergency obstetric care available. But it doesn't mean every woman needs the full-blown emergency obstetric care all the time.

BUT AREN'T WE JUST TRYING TO PROTECT THE HEALTH OF MOTHERS AND BABIES?

Yes, but what we're learning from the research is that we're actually doing them a disservice. When we treat every birth like an emergency, when we induce every woman who goes over her due date or over forty-one weeks, we see more cesareans, and when we see more cesareans we see more problems. This is partly to blame for the recent rise in maternal mortality. And a very large study of 5.7 million babies done by a U.S. Centers for Disease Control statistician found that babies born by cesarean were three times more likely to die within the first month of life.

So what we really need to do is understand why that is and to reexamine the idea that cesareans are better for babies. They don't seem to be, and they definitely interrupt breast-feeding.

YOU ATTENDED SEVERAL BIRTHS IN RESEARCHING YOUR BOOK. WHY?

Before I even put together a book proposal, I decided I needed to see a birth to figure out if it was something I could handle. I don't have kids. So I went to a birthing center in El Paso, Texas, to interview the midwives. They invited me to work a twenty-four-hour shift. I spent the day shadowing a couple of midwives as they did their prenatals, and I talked to some of their clients. At about nine this woman came in, and she was in labor. She did not lie down once. She kept walking around the room. Within the hour her water had broken and she birthed that baby standing up. It was wonderful. It's an amazing rush to witness that. I saw probably the most optimal birth experience you can imagine.

IS THAT THE SOLUTION: MORE MIDWIVES?

I think one major piece of the solution is to create a maternity care system where midwives are primary maternity care

providers. They support the physiological birth process and leave the emergencies and the problems to the doctors, because that's what *they* are good at. And if a woman needs to be induced into labor, we have really good tools to do that.

One problem we have to solve is that physiological birth doesn't seem to fit into our health-care system. Hospitals are businesses, and doctors' practices are businesses. So many physicians said to me, "I have to pay $100,000 a year in malpractice insurance now, and I have to take twice as many clients as I used to just to make up my salary and keep the quality of life I had. That means I spend half the time with patients in the office." It's impossible to expect a doctor to wake up all hours of the night and stay with a woman throughout her labor. That's not what they were trained to do; they have far too many clients to do that for everyone.

Once you get to the hospital, there's a ticking clock. Nurses would say to me, "I can't have them taking up beds. If you're in early labor, you're taking up a bed, you're not taking any intervention, you don't belong here."

We need to create spaces like birth centers. Not every woman wants to have a home birth, and birth centers, where they exist, are extremely popular. They're sort of that middle ground. They're a place where women can get support for physiological birth from midwives and also have a connection to a hospital. Midwives are experienced at recognizing problems and transporting seamlessly. But birth centers are having a hard time staying in business, because they have malpractice insurance problems, too. Their insurance is also quadrupling.

I think that most women want to do what's best for themselves and their babies. It's not that they want a natural childbirth. They just want a normal birth.

THE HIGH COST OF CESAREANS

Until about 1970, fewer than 5 percent of births in the United States were by cesarean section. By 1996, the rate was 20 percent, and in 2005 it was just over 30 percent.

"In cases of high-risk mothers or infants at risk, cesareans are usually appropriate," says Eugene Declercq, a School of Public Health professor of maternal and child health. "The real point is that clearly 30 percent of the mothers and infants are not at high risk."

Women face longer and more painful recovery times and longer hospitalizations after cesareans and greater risks of uterine rupture in future pregnancies, among other complications, according to Declercq.

The c-section rate has climbed for a variety of reasons, among them the fear of malpractice lawsuits. But don't blame the moms. Declercq says it's a myth that the rising cesarean rate is the result of maternal request.

Declercq was the lead author of the report "Listening to Mothers," which surveyed 1,580 mothers in 2002 and 1,573 in 2006 on their childbearing experiences. Mothers who had had a cesarean were asked what the reason was, who made the decision, and when. Of 252 participants who had undergone a primary, or first, cesarean, only one reported that she had requested a cesarean with no medical reason. Other studies in the United States and abroad confirm those findings, Declercq says.

At the same time, he says, there is no evidence that the birth process is getting riskier or that there are more cases of fetal distress, breech births, or prolonged labor, which might account for the growing number of c-sections.

What has changed, says Declercq, is obstetrical practice. Cesareans have become safer as obstetricians have become more skilled in performing them and as anesthesiology has improved. On the other hand, as they do more c-sections, obstetricians may become less skilled at managing vaginal births. "If you have a provider who has never done a vaginal breech birth," he says, "then of course you should have a cesarean if your baby is breech. So step by step, if you close off breech birth, then twin births, you start increasing the number of categories in which cesareans happen."

Any efforts to reduce the number of c-sections performed in the United States will have to be led by women, says Declercq. In the 1960s and 1970s, women fought to bring their partners into the delivery room and for more pain-relief choices. "It's a different set of issues now," he says. "And the question is, will women get as involved in preventing unnecessary cesareans?" CKB

Home of the Brave

PRESIDENTIAL COURAGE MIGHT SOUND LIKE AN OXYMORON TODAY, BUT IT WASN'T ALWAYS

BY TAYLOR McNEIL

EARLY IN 1951, President Harry Truman faced a hard choice. Douglas MacArthur, General of the Army, commander of the United Nations forces fighting in Korea, and national hero, had disobeyed yet another directive from his commander-in-chief, scuttling a Truman peace initiative to the Chinese by violating a presidential gag order. Truman viewed MacArthur's insubordination as a threat to civilian control of the U.S. military, and beyond that, to constitutional rule.

His advisors warned that it would be political suicide to fire MacArthur — the general was simply too popular. But "the time had come to draw the line," Truman later wrote, and he relieved MacArthur of his command on April 11, 1951.

"It literally cost his presidency," says Thomas Whalen. Truman's approval ratings never again rose above 33 percent. "To his credit, Truman felt that this was the right thing to do, and it was important to the long-term interests of the country. It was the quintessential moment of presidential courage."

That term might seem an oxymoron today, but Whalen, a College of General Studies associate professor of social studies, believes the time is right to remember that winning the next election wasn't always the only goal for our leaders. In his new book, *A Higher Purpose: Profiles in Presidential Courage* (Ivan R. Dee), Whalen resurrects Truman and eight other American leaders and the moments that defined their political careers, using John F. Kennedy's 1955 best seller, *Profiles in Courage*, as a touchstone.

When Harry Truman fired Douglas MacArthur in 1951, it made headlines around the world, including London.

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Presidents kowtow to public opinion, of course; that's politics. But Whalen thinks we're forgetting that it doesn't have to be that way. Some of his examples, like Chester Arthur and Grover Cleveland, are seldom remembered as heroes. Other exemplary acts of political courage are more well-known, such as Abraham Lincoln and the Emancipation Proclamation and Kennedy and the integration of the University of Alabama. At least one, Gerald Ford's pardon of Richard Nixon, is open to debate. But that's what Whalen wants.

"I'm a Socratic teacher," he says. "I want a debate to begin. I want people to discuss my choices and the whole notion of political leadership and courage."

Take Chester Arthur, who became president suddenly in September 1881, following the assassination of James Garfield. Arthur had been a New York politician, whose nickname, Gentleman Boss, reflected his association with the patronage system that ruled the day.

Sure enough, when he was sworn in, "all his friends were expecting a fine old time, pigs to the trough," says Whalen. "But he did a complete 180 and became a model president." Today Arthur is best known for signing the Pendleton Act, which established the bipartisan Civil Service Commission, created to eliminate the patronage system that pervaded the federal government. He knew what the political consequences would be, Whalen says, and sure enough, he didn't get his party's nomination for a second term. "That was the price, but he did the right thing."

"Truman felt this was the right thing to do. It was the quintessential moment of presidential courage." —Thomas Whalen

When confronted with difficult choices, some presidents, like Arthur, make decisions that lead to personal redemption, Whalen says. "They see the light and act on their conscience."

That was certainly the case with Kennedy, who until mid-1963 paid scant attention to civil rights. "He had a really abysmal record on this during the first two years of his presidency," Whalen says. "But he saw the civil rights marchers beaten viciously in places like Birmingham, Alabama, and it was a turning point for him."

The catalyst was a developing crisis at the University of Alabama at Tuscaloosa. Two black students had been admitted under federal court–ordered desegregation, and Governor George Wallace was threatening to stop them from enrolling. Kennedy called in the National Guard, and the students matriculated. In a nationally televised speech in June 1963, he told Americans that they were "confronted primarily with a moral issue. It is as old as the Scriptures and is as clear as the American constitution. The heart of the question is whether all Americans are to be afforded equal rights and equal opportunities."

Kennedy knew that if he went against the segregationists, he had a good chance of losing the South and the 1964 election. "But he thought that he would be condemned in history if he didn't do something," Whalen says.

"He put the full legal and moral authority of the presidency behind the civil rights movement," adds Whalen. "Not since Lincoln had a president dared to do that. He was very conscious of the fact that it might end his political career. But it was the right thing to do."

Whalen's final example — Ford's pardon of Nixon — happened thirty-three years ago. Does that mean subsequent presidents have lacked courage? Not necessarily, Whalen says. "I think in many ways I'm too close to it. But," he adds, "no one does stand out to me." B